

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-010457
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 504

FILED APR 9 1962

VS 300
Rev. 4/59

10397

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) SPRINGFIELD		Length of stay in 1b 8 DAYS	
c. FULL NAME OF (If NOT in hospital, give location) ST JOHN HOSP.		d. STREET ADDRESS (If outside, give location) 244 E. JACKSON	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle YAN Last BRAKE		4. DATE OF DEATH Month MAR Day 26 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-6-1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. MAC. OPERATOR		11. BIRTHPLACE (City and state or country) MISSOURI	
13a. FATHER'S NAME HILHARD BRAKE		14. NAME OF MOTHER OR WIFE HANNAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. [REDACTED]	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease		INTERVAL BETWEEN ONSET AND DEATH > 3yr	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic bronchitis - Spontaneous AS		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES A. NO	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour [REDACTED] a.m. [REDACTED] p.m.	Month, Day, Year [REDACTED]		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION SPRINGFIELD	
21. I attended the deceased from 11/13/61 to Death and last saw her alive on 3/26/62 Death occurred at 11:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature]	22b. ADDRESS 689 Cherry Springfield MO	22c. DATE SIGNED 3/30/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 3-26-1962	23c. NAME OF CEMETERY OR CREMATORY MARSHFIELD	23d. LOCATION (City, town, or county) MARSHFIELD MO
24. FUNERAL DIRECTOR BARBER-EDWARDS	25. DATE RECD. BY LOCAL REG. 4-2-62	26. REGISTRAR'S SIGNATURE [Signature]	

(Licensed Embalmer's Statement on Reverse Side)

Andres H. Hahn, M.D.
USE BLACK INK
OR
TYPEWRITER RIBBON

Permit issued 3-26-62

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.